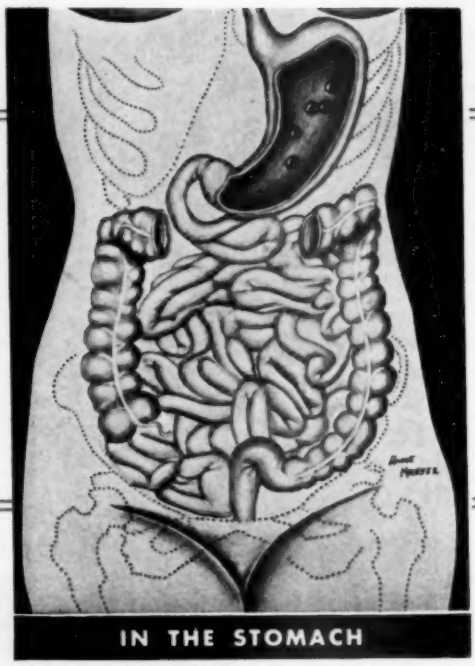
R.N.

A JOURNAL FOR NURSES

OCTOBER 1940

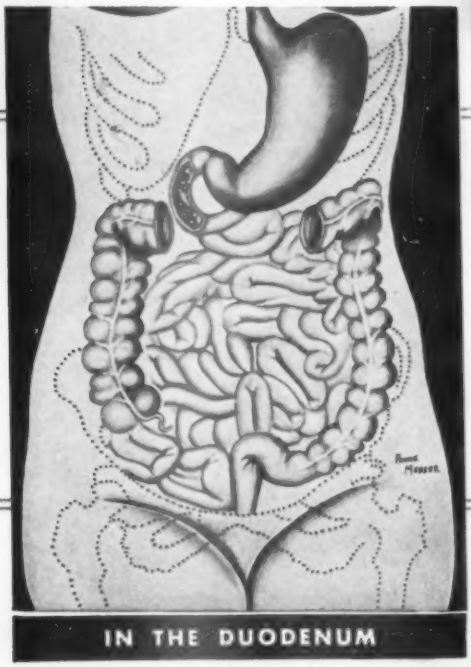
THE PROFESSIONAL LAXATIVE



IN THE STOMACH

ENTERIC COATED

Taxol Tablets are enteric coated. Hence they are not dissolved in the stomach and thus avoid gastric irritation. Neither is the potency of the ingredients impaired by the gastric juice.



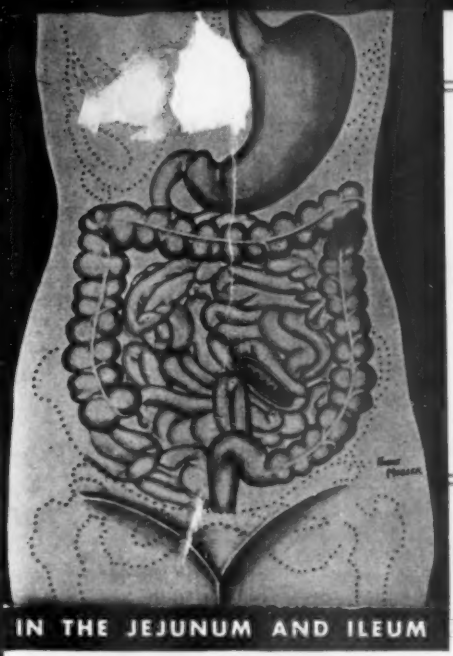
IN THE DUODENUM

QUICK INTESTINAL SOLUBILITY

Taxol Tablets are quickly dissolved beginning in the alkaline succus entericus of the duodenum. Laxative action therefore begins at the beginning of the intestinal tract.

TAXOL

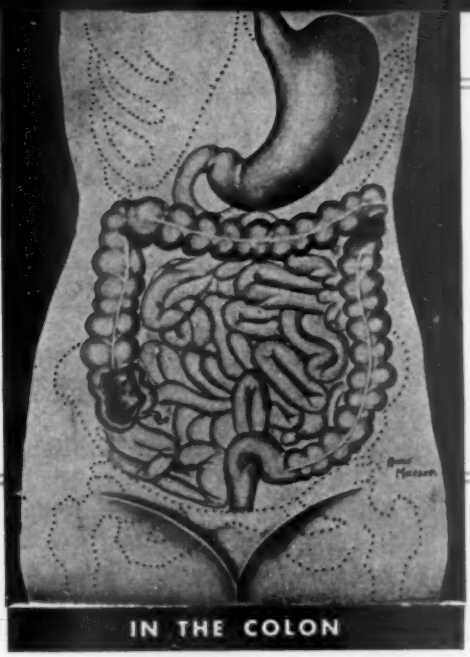
THE STRICTLY ETHICAL LAXATIVE MANUFACTUR



IN THE JEJUNUM AND ILEUM

PROGRESSIVE ACTION

Solution of Taxol Tablets begun in the duodenum is continued throughout the jejunum and ileum. No part of the intestinal tract is neglected by Taxol.



IN THE COLON

HELPS THE COLON

With the enteric coating completely dissolved, the medication is delivered in the cecum—where it produces gentle stimulation of the entire colon. An antispasmodic ingredient prevents cramps or griping.

HOW TAXOL ACTS

TAXOL Tablets are the professionally advertised laxative so widely prescribed by many physicians. They produce a comfortable movement in six to twelve hours, without cramps, griping or nausea.

The advantages of Taxol Tablets are graphically shown by the four anatomical drawings.

FORMULA

Each tablet of Taxol contains aloes 2/5 gr., bile salts 1 gr., desiccated pancreas and duodenum ¾ gr. and extract hyoscyamus 1/13 gr., with agar-agar as a chemical binder. The synergistic combination of aloes with bile salts produces an unusual anthraquinone tonic laxative action.

DOSAGE

The average dose is 1 to 6 tablets daily as needed, before meals or before retiring. Taxol is supplied in boxes containing 50 tablets.

Samples of Taxol Tablets are available to registered nurses for their personal use. Simply sign and mail this convenient card for your complimentary supply.

TABLETS

R LOBICA, INC., 1841 BROADWAY, NEW YORK, N. Y.

IN *This* ISSUE

October 1940 Vol. 4, No. 1

A JOURNAL R.N. FOR NURSES

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Debits AND CREDITS

SPECIAL SERVICE

Dear Editor:

I live in a moderate-sized community where there are about ten doctors. Most of these men do not employ graduate nurses as their office work can usually be handled by a less experienced person at a small salary. Yet there are times when a graduate nurse could be of great benefit. Home deliveries, special treatments, hourly care, for instance.

Would it not be practical for these physicians to have one or two graduate nurses to provide this kind of service for all ten? The nurses could be called when the need arose. Each doctor could have a graduate when he wanted one and yet not have the expense of full-time employment. With ten or twelve doctors in the community, the nurse should be kept busy.

What do you think of such an idea?

R.N., Towson, Md.

[R.N. *approves. For helpful suggestions see Marie Craig's article, "Treatments by the Hour," July 1939 issue.*—THE EDITORS]

CREDIT DUE

Dear Editor:

Your recent article on the five-day syphilis treatment credited me with the "first successful . . . intensive administration of arsenicals." While this is essentially correct, credit should be given Scholze for proposing such administration of 606, and to Pollitzer for his subsequent review of its possibilities. The efforts of both these men antedated my own.

Herman Goodman, M.D.
New York, N.Y.

SOUTH AMERICA

Dear Editor:

Enjoyed your article "Nursing Below the Equator" very much. I am a bit of a traveler myself and for some time have wanted to get a position in an industrial firm in South America. This particular article surely gave me quite a bit of information—things I would never have thought of myself. Some day I may venture—though I am past forty . . .

R.N., Washington, D.C.

[*Jean Martin White, who authored the article, is proud of the fact that she is 54 and starting a responsible new nursing assignment in Argentina.*—THE EDITORS]

MISNOMER

Dear Editor:

Your article, "Give the Men a Break," honors me by giving me the title of registered nurse. However, I fear I must refuse to accept the honor for I am not an R.N. . . . It is true I spent two years as a male nurse at the old Deaconess Hospital from 1903 to 1905. It is likewise true that during my seven years of college and seminary days I nursed not only the boys at the college and seminary, but through the kindness of the head deaconess of our hospital, I nursed such patients as she could provide for me during my vacations —Christmas, Easter, and Summer . . .

But having spent only two years in the nursing field, I could not very well receive the R.N. degree. I just can't parade under feathers that I have no right wearing!

Paul R. Zwilling, president
American Protestant Hospital Assn.
St. Louis, Mo.

SICK-NURSE FUND

Dear Editor:

Will you please thank R.N. readers for sending me the magazine while I am ill? I want them to know how truly grateful I am.

I've always enjoyed this journal, and I'm sure I'll derive even more pleasure from it now that I'm sick.

As soon as I can work again, I'll repay the money, so that some other nurse may benefit by this happy idea.

R.N., Syracuse, N.Y.

[*Readers will be glad to know that the Sick Nurses' Subscription Fund now stands at $35, with more contributions*

CIGARETTE DIFFERENCES

as shown by the rabbit-eye test

Into *this* eye was instilled the smoke solution from Philip Morris Cigarettes—

Into this eye was instilled the smoke solution from *ordinary* cigarettes—

OBSERVATION: Smoke solution from ordinary cigarettes produced *3 times* the edema produced by Philip Morris cigarettes.*

CLINICAL TESTS: When *smokers* with irritation of the nose and throat due to smoking changed to Philip Morris, every case of irritation cleared completely or definitely improved.**

From Tests Published in *Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245. **Laryngoscope, 1935, XLV, No. 2, 149-154.

rolling in every day. Seven nurses who are inactive through illness have received free subscriptions, to date. Lack of space prevents printing all their enthusiastic thank-you notes.—THE EDITORS]

CHEVRON

Dear Editor:

Apropos of letters published in R.N. from time to time relative to uniforms, I am convinced that short sleeves are far more sanitary and comfortable than long sleeves. It occurred to me that a chevron, sewed on the sleeves of uniforms, would immediately distinguish registered nurses from practical nurses and others who wear white uniforms. This chevron might be a cross in red or blue carrying the symbol R.N. and the nurse's State registration number.

What do others in the profession think of this?

R.N., New York, N.Y.

ETHICS

Dear Editor:

I have an opportunity to join the staff of a beauty shop, giving massage treatments. The manager of the shop feels that having an R.N. on her staff would add to her prestige in the community. Do you think it would be ethical for me to accept this kind of position?

R.N., Lewisburg, Ala.

[*Must you accept it? Arrangements of this nature always seem impractical when there are innumerable nursing activities to which the registered nurse might apply her talents. Obviously, an* R.N. *would lend dignity to any beauty shop. But would employment in a beauty shop bring dignity to the* R.N.?—THE EDITORS]

MAN, THE UNKNOWN

Dear Editor:

Why did usually alert R.N. omit a picture of the men nurses at the 1940 Biennial in Philadelphia? They were there and cannot be so easily ignored. Why not a story of the part men nurses have played in the history of nursing?

Have you any information about the status of men nurses under the conscription program? Will training schools be permitted to retain men students until they graduate? Will men graduates be exempted from peace-time service in the army?

A. Jackson Carpenter, R.N.
Waverly, Mass.

[R.N. *has no wish to overlook the activities of men nurses. Alert reader Carpenter apparently missed "Give the Men a Break," published in July. So far, it does not appear that men nurses will be exempt from military service.*—THE EDITORS]

Dear Editor:

So you can hire two women nurses for the price of one man nurse! And women are weak, incompetent, hysterical, and thoughtless! Is the author of "Give the Men a Break" trying to exact an "eye for an eye"? If this is his usual attitude, the women haven't been half hard enough on him.

Let me tell you, if cohesiveness were the thing sought for in nursing instead of this perpetual ascendancy of sex, there would be no question of low wages or anything else: we'd all progress on the

ACTION Below The Surface in Local Congestion

Below the skin, that's where MINIT-RUB exerts its stimulating action. Counterirritation stirs local circulation for capillary dilation. Improved lymph and cell activity help dispose of congestion waste. Local analgesia quickly comforts irritated nerves and muscles. MINIT-RUB refreshing relief is indicated in . . .

Sore, aching, strained muscles — local congestion of uncomplicated colds — simple neuralgias — head colds — upper respiratory tract chest colds.

MINIT-RUB is clean, convenient, economical . . . Its action is prompt and prolonged. Rub a bit into your hands and feel its effects.

MINIT-RUB

The Modern Rub-In

STAINLESS • GREASELESS
VANISHING

Send Coupon for Generous Trial Tube of MINIT-RUB.
BRISTOL-MYERS CO.
19-RN West 50th Street, New York, N. Y.
Send a generous trial tube of MINIT-RUB to . . .

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basis of merit and merit alone. It's the same old trouble all over again. Woman, foolishly, has so long kidded man that he has really come to believe he is superior in everything!

A man nurse is as much a part of the nursing field as the hospital itself. But the fact that he is a *man* doesn't mean a thing. He's sexless, so far as the profession is concerned . . .

Edna Davis, R.N.
Skyland, N.C.

Dear Editor:

I enjoyed the fair, sportsmanlike manner in which the male nurse presented our case. Personally, I consider I have not been particularly maltreated as an individual. But with male nurses as a group it is different. Women who have been seeking equality for themselves have been too lax in extending that equality in the profession where they have unique opportunity to do so.

In one of our local hospitals, young men who would be a credit to the profession have applied for admission to the training school. The administrators of the institution—who knew them well and were heartily in favor of accepting them—were told by the State board that it was not being done in this State!

Floyd Fought, R.N.
Lansing, Mich.

Dear Editor:

I'm all for "giving the men a break"!

Recently I had the pleasure of being on a private case with men nurses filling out two of the three eight-hour shifts. The patient was a heavy, elderly man with cardio-renal complications following an operation on the spleen. Those men nurses were just as gentle and competent as any of the fairer sex I've ever worked with. And they were certainly not as fagged at the end of eight hours as I!

Come on girls, don't be priggish!

Ada Appel, R.N.
Cleveland, Ohio

Dear Editor:

The anonymous article on men in nursing was excellent!

I, as a male nurse, have suffered many indignities at the hands of sister professionals. Only after I devised short-cuts in routine tasks and accomplished re-

sults beyond the scope of the ladies did they cease to refer to me as "only a male nurse."

The majority of doctors with whom I have worked have expressed a decided preference for the services of men nurses. They have found that men possess greater initiative in unusual circumstances and greater common sense proficiency in ordinary nursing . . .

Much that has been done to improve the lot of the hospital nurses has been instituted by men . . . Women, it appears, tend to shun any activity that may antagonize their employers. Men are less squeamish about treading on toes for a just cause.

Because men nurses are immune to the "glamor" of the intern staff, they are better able to concentrate on the job at hand than many of the young women nurses who require frequent recesses for revamping their charms . . .

Louis E. Estler, R.N.
Bellerose, N.Y.

BROKEN SHIFTS

Dear Editor:

I appreciate your comments concerning the A.N.A. I for one have been tempted to think they are not accomplishing much toward the eight-hour goal. This attitude is probably due to the fact that so few hospitals really do eight-hour shifts. The day is so broken that we feel as if we are doing twelve hours. In some cases we work from 8:00 A.M. to 11:00 A.M., and from 6:00 P.M. to 11:00 P.M. How is that for breaking up eight-hour duty?

Edith V. Fulton, R.N.
Covina, Calif.

NEW EASY WAY TO AVOID THIS MESSY DUTY

NO BRUSHING!

simply soak patients' FALSE TEETH clean and sweet with

POLIDENT

Never again need you vainly try to scrub tough mucin-film, tarnish and food debris from stained, slimy dentures. From now on, let POLIDENT do the dirty work.

POLIDENT—as thousands of nurses have discovered—simply *soaks* plates and removable bridges sweet, odorless, sparkling clean and pure. NO HANDLING! NO BRUSHING! HYGIENIC! All you do is place the denture in ½ a glass of water, add a little POLIDENT, let plate soak for 10 to 15 minutes, rinse—and *that's all!*

GOOD NEWS FOR PATIENTS, TOO

Your patient, as well as yourself, will appreciate learning about POLIDENT. For POLIDENT *dissolves away* all traces of dingy film and discoloration . . . *soaks* out odors . . . leaves plates looking LIKE NEW. Its thorough cleaning action gets into every tiny crevice where brushing can't even reach. It won't harm dentures . . . is used and recommended by leading dentists everywhere.

WRITE FOR YOUR FREE SAMPLE—TODAY. Send name and address to Hudson Products, Inc., Dept. A1, 220 West 19th St., New York, N. Y.

WORKS LIKE MAGIC

Soak 10-15 minutes—Rinse—That's All!

Brushing false teeth is *dangerous* . . . as well as unpleasant. Polident minimizes danger of hand-infection from unclean plates . . . lessens possibility of scratching, dropping or otherwise damaging expensive dentures.

POLIDENT

First guns in the nursing defense program were fired last month with the formation of the Nursing Council on National Defense. Here is a summary of recent developments and their effect on your career.

BY MONA HULL, R.N.

• Meet the front-line defender of Uncle Sam's health and morale: Yourself! Mary Jones, R.N., general staff nurse in (let's say) Milford, Illinois. In the nation's new preparedness program, your home town and a million others are prospective defense centers. You, your hospital, and your district are the standing health army.

As the Government perfects plans to guard health, should war occur, nursing has orders to stand by. Strong local organization, and every-day nursing jobs expertly done, will be as important as guns and planes.

"What's my place in the defense program? How will nurses be used?" you ask, as you read of mobilization and conscription. Facts all point to one conclusion: If war comes to the United States, it will be won or lost in your community and others like it. The Government regards you as a trained expert, stationed—for the time being—where you are most needed: at home.

To understand why Uncle Sam values you so highly at home, in your own job, examine the broad medical defense picture. It was well described to this magazine last month by Dr. Iago Galdston, who heads the information bureau of the New York Academy of Medicine. "Today's total war is won on the home front," he said. "The battle of Britain is a good example. The problem is one of disruption of civilian life—evacuation, maintenance of morale, safeguarding of health under all sorts of disturbing conditions. More than ever, in a war situation, doctors and nurses are needed to maintain health standards in the midst of a disorganized population."

General-staff and private-duty nurses will be in demand because of their unequalled background of practical experience, medical authorities agree. From British experience it is clear that many nurses are needed to care for the wounded. But among the most pressing

health problems are pediculosis, enuresis, and venereal disease among the evacuated populations. Nurses with general family experience will be needed to deal with such conditions.

To be sure that you'll be on hand for the all-important job of keeping your community protected, the Government has launched the biggest health check-up in history. Not only nurses but doctors, dentists, and sanitary engineers will be "mobilized" to protect their communities. The United States proposes, with the help of professional organizations, to list all available trained men and women and their qualifications for service.

Surgeon-General Thomas Parran, talking to nurses recently, said: "The first task is the need for listing and classifying professional and technical personnel in the country . . . to investigate who should go, who should stay to operate an *essential civilian* service . . . The physical fitness of men, women, and children, their freedom from disease, their morale or mental stamina, will determine almost entirely the effectiveness of all other defense efforts."

Toward this end, the U.S. Public-Health Service has outlined a plan for State health boards to study problems locally. Such advisory bodies as the "New York State Commission to Formulate a Long Range Health Program" will bring medical and nursing leaders together with State officials. Through such groups, the Governors and State departments will be kept informed of the exact status of all health measures. Reporting to the State boards all over the country will be County Health Committees. With medical supervision, these county groups will do the actual local planning.

First step of the Federal Goverment was to take stock of its own departments. An estimate of the war time requirements of the army, the navy, and the public-health service revealed a potential nurse shortage. For every million men on fighting lines, 4,000 active field nurses will be needed, experts say. The five Government nursing corps, at the present time, employ a total of only 7,000 R.N.'s—which is why the Government has announced expansion of nearly all of its services and reserves. [For requirements, see chart on the following pages.] The army alone will

Smith from Black Star

add 4,000 nurses to its active list before July, 1941. Selections will be made from the first reserve of the American Red Cross, said Major Julia O. Flikke, Army Nurse Corps director.

Beyond this, the U.S.A. must know its community resources. Through the American Medical Association, 174,000 M.D.'s will be asked to register their whereabouts and availability for service. To take a similar roll call of nurses is the next step.

Some time within the next few months, you (and 250,000 other R.N.'s) will receive a questionnaire. It will inquire into your experience and training . . . Are you single, married, widowed, or separated? How many languages do you speak? Are you in good health? Do you drive a car? Most important of all, you'll be asked where and how you'd like to serve in an emergency situation—in your own community, or elsewhere if needed . . . for a salary, or on a volunteer basis. You'll be asked to mention what work you believe you can do best.

Advisory agency for this vast census of nursing resources—the first of its kind—is the newly formed Nursing Council on National Defense, made up of national nurse organizations and Government nursing-service heads. Major Julia C. Stimson, A.N.A. president, is chairman. Federal sponsor for the count is the U.S. Public Health Service, and Pearl McIver, senior public-health nursing consultant, will probably be director. State and local nurse groups will distribute and collect the questionnaire forms.

Credit the New York State Nurses' Association with the initial thinking which stimulated development of the nationwide nursing census. Setting up its own plans for a nursing survey of the State, New York offered to let its findings be used as a basis from which the national program might develop. Whether or not that offer was rejected is not clear at this writing. Reliable sources in Washington, D.C. report, however, that a questionnaire (presumably New York's) has been prepared and is awaiting approval by the Federal Central Statistical Board. When that approval comes through, it is said, the survey will be launched in the District of Columbia, where it will be tested before extension to the rest of the country.

If the census is successful, the quali-

	STATION
ARMY 	Army hospitals; general dispensaries: Surgeon General's office; army stations in U.S., Hawaii, Porto Rico, and Phillipines.
NAVY 	Naval hospitals in U.S., Guam, Samoa, Cuba, Hawaii, and Phili ines; Hospital Ship, U.S. , Relief; naval transports.
Veterans' Adm. 	85 veterans' hospitals in every State, except New Hampshire and Rhode Island.
U.S.P.H.S. 	Majority in marine hospitals and relief stations. Also, Federal prisons.
INDIAN 	Indian reservations in U.S. and Alaska, including Indian hospitals and dispensaries.

HOURS	SALARY	EDUCATIONAL REQUIREMENTS	AGE	SPECIAL TRAINING & REQUIREMENTS†
Eight-hour day*	$840-1,560 with maintenance; 30 days' vacation.	High school graduate; graduate of approved school of nursing; State registration.	22-30 On first appt.	Member A.N.A., Red Cross First Reserve; Good physical condition; single.
Eight-hour day*	$840-1,560 with maintenance; 30 days' vacation.	High school graduate; graduate of approved school of nursing plus 1 to 2 years' general experience; State registration.	22-28	Good physical condition; physical examination required; single.
Eight-hour day*	$1,620-3,200; 30 days' vacation.	High school graduate; graduate of approved school of nursing. State registration.	Not over 35	Good physical condition; U.S. Civil Service examination.
Eight-hour day*	$1,620-2,900; deductions for maintenance.	High school graduate; graduate of approved school of nursing within 8 years; State registration.	Not over 35	Good physical condition; minimum height, 5' 2"; minimum weight, 105 lbs.; U.S. Civil Service examination.
Eight-hour day*	$1,620-2,600; deductions for maintenance and retirement.	High school graduate; graduate of approved school of nursing within 12 to 15 years; 2 years' graduate experience; State registration.	20-40	Good physical condition; U.S. Civil Service examination.

*Wherever possible †All must be American citizens

fications and experience of all nurses will be on file to assist health authorities in selecting personnel—should an emergency arise. Such a record of availability will insure a safe quota of expert nurses for home service at such time as special reservists might be called away to front-line posts.

Your first important act in the defense situation, therefore, is coming up in the near future. When the nursing census begins in your State, make sure that you're included, that you are accurately registered, that you know what part you are ready to play in the nursing set-up. Can you best serve in public health, in an institution, or as a private-duty nurse? Can you leave your own community? Can you give part or full time during a defense situation? It is not always easy to decide—so start thinking now. [*Continued on page* 37]

LILLIAN WALD, R.N.

Death came, last month, to the founder of the House on Henry Street. Militant, fearless, but above all human, she leaves nursing the heritage of her professional genius.

● One night in 1906 in New York City, Lillian Wald was entertaining guests for dinner. She had been a member of the Mayor's Pushcart Commission for quite some time. And presently, in the midst of the dessert course, a delegation of fish peddlers arrived for a conference. Some of Miss Wald's dinner guests asked if they might sit in on the meeting. But the peddlers said no; they wouldn't be able to talk with strangers present. "Miss Wald is different," explained the spokesman. "We can talk to her. She's as good as a fish peddler!"

That was Lillian Wald in a nutshell. She could be a fish peddler, a striker, a suffragette, or a pacifist. But all the time she was primarily a nurse. Nursing led her headlong into all the movements of the day. And she didn't try to keep nursing out of any of them.

Progressive even today is her theory that politics wouldn't hurt nursing, that nursing could do a lot of good in politics. For Lillian Wald, nursing was mixed up in every city ruling, in every social movement, in every election, and with every office-holder. Was nursing

contaminated? On the contrary. It was recognized for the first time as a militant body that got things done for better living.

The project for which Lillian Wald will be forever famed in nursing history is the framing of the concept of public-health nursing and the founding of the Henry Street Settlement in New York City. "But as soon as I started working in the interest of those East Side babies," she told her friend and biographer, R. L. Duffus, "I was really in politics."

And in politics she stayed for the rest of her long and colorful life. In his book, "Lillian Wald, Neighbor and Crusader,"* Mr. Duffus describes how every significant social movement in the past forty years has borne the imprint of her energetic support. She was in the foreground of the early struggles for better housing in New York City. She helped establish trade unions for women. It was she who "put the fist in pacifist." She pestered the White House about launching a Children's Bureau. She campaigned for the vote for women. But it was all quite logical to Miss Wald —for every one of those activities was tied up in her mind with better health for the nation.

Even as a girl Lillian Wald was fascinated by people, collectively and singly. She went into nursing straight from the confines of Miss Cruttenden's "English-French Boarding and Day School for Young Ladies and Little Girls" in Rochester—because nursing seemed vitally connected with people. After her training in New York City at the New York Hospital, and a year at the Women's Medical College, she went to live in the East Side slums—not because she knew anything about settlement work but because it was the quickest way to help those unfortunate people.

Lavinia Dock visited Miss Wald and her co-worker, Mary Brewster, when they had just recently been settled in their tenement. "Their tiny rooms were charming in the simplicity of clean, bare floors, six-cent white curtains, and green growing plants," she wrote. "They did all their own work, except laundry and scrubbing, and got acquainted with their neighbors, their chief solicitude being to approach these less fortunate fellow mortals upon the neighborly and individual side, and to make their own impression as friendly souls before whom all the confidence and problems of living might be safely opened. Their nursing was their open sesame."

It was this personal touch which led to Henry Street's famous family approach and to public health's later techniques. But home nursing in New York's ghetto also started Lillian Wald on broader health issues. As she sat writing reports long after midnight on winter evenings, her feet in the oven to keep warm, she saw one fact with increasing clearness: To keep people well, nurses would have to go beyond nursing to the social issues of the day.

Thus it was that the nurse from Henry Street went to Mayor Seth Low to demand nurses for public schools, creating the idea of the school nurse. So also, a year or two later, she approached Teddy Roosevelt with her idea for a national children's bureau (which, seven years later became a reality). It was logical too, at this time, for Miss Wald to be appointed to the Commission on Aliens in New York State. Immigrants were her customers and friends and, therefore, her problem.

The labor question, arousing bitterest controversy all over the country just before the World War, found Henry Street's nurse again in the front line of battle. She expressed her belief, seconded twenty-five years later by law, that the union movement "means higher opportunities and better shop and home conditions" for all laborers, and "is keeping alive the basic essentials upon which our republican civilization stands." [*Turn the page*]

*The Macmillan Company, 1939.

Such views cost Lillian Wald the support of conservatives. But she would not give up beliefs for any amount of contributions for the settlement. Far from suffering from its leader's views, Henry Street flourished. Its visiting-nurse service proved so successful that by 1913 there were branches all over Manhattan and the Bronx. Headquarters took a wide view of nursing responsibilities, maintained kindergartens, carpentry shops, dancing schools, gymnasiums, debating clubs, and literary societies. Meanwhile, Miss Wald had stumped for Theodore Roosevelt and joined the suffragettes in their demand for the vote. Even the right of women to go to the polls she considered a step toward better living conditions.

When the Henry Street Settlement celebrated its twentieth anniversary, it had acquired a permanent endowment fund and enthusiastic support from rich business men and poor immigrants alike. But its leader wasn't resting on her laurels. She was organizing pacifist sentiment against American entry into the war. War was not really waged against men, she said in a 1915 speech, but against women and children . . . An all-day meeting was held at Henry Street; from it developed the American Union Against Militarism with Lillian Wald as president. Such famous social consciences as Jane Addams, Max Eastman, and Rabbi Wise were members.

Miss Wald's response was typical when the United States did enter the World War. She went to Washington to plan for nurse service on a national scale. Her director of nurses at Henry Street, Annie Goodrich, was later made dean of the Army School of Nursing. Miss Wald was on three committees for the Council of National Defense. "I slept like a fireman," she said, describing those days. Day and night, she was ready for emergency calls.

Always the true public-health nurse, Miss Wald kept one eye on what she called "home defense"—the health of the people at home. Her hunch that preparedness was needed at home was borne out in a terrifying manner with the influenza epidemic of 1918. New York became, in her words, "a great field hospital." Who headed the Nurses' Emergency Council? Henry Street's Lillian Wald. She used this crisis to insist again that "more trained nurses are needed, not only to care for the sick, but to teach . . ."

Though often ill from years of twenty- and twenty-four-hour activity in her youth, Miss Wald kept campaigning for social rights. During the great depression she went to bat for an adequate relief system for the poor, for more milk for New York City. She maintained stubbornly that it was her right to take sides on political issues as she saw fit.

Meanwhile, the Settlement proved by an enormous fortieth anniversary celebration in 1933 that it had not suffered by the militant outlook of its founder. Henry Street and Miss Wald both were institutions of national and international importance.

Despite physical handicaps, and almost until her death last month, Lillian Wald continued to campaign for people and for democracy. One of her favorite stories, a dig at intolerance, repeats the remark of a Henry Street native who said, "I'll tell you what. The day will come whin we Protestants and Catholics will fergit our bigotries and come together to wipe the Jews off the face of the earth!"

The keynote of a life service against disease, inequality, and injustice was never better sounded than by Miss Wald herself. "Somehow," she said one time to two women textile strikers who visited Henry Street, "I do like rebels!"

• Hospital working conditions in 15th Century France were so awful that hardly any but reduced and aged prostitutes could be persuaded to enter them as nurses. By the 16th Century, the words nurse and prostitute were synonymous in all France.

MARY CAME BACK

● She served for nine months overseas with a volunteer ambulance unit . . . "I know nurses are needed," she said when she signed up. "I want to be where I can do the most good."

Now she is home—doing general staff nursing in a large city hospital. "That," says Mary, "is where I really belong. But it almost cost me my life to find out."

To many, a general staff post may seem dull and routine after a year of service under fire. Mary says it isn't. She has nursed the sick, the hungry, the homeless here and abroad—and they all seem to be poured from the same mold. A surgical patient in one of our private rooms or county wards, she says, has much the same need as a wounded soldier in a field hospital . . .

It is traditional for nurses to choose the most demanding assignment to be found. In our anxiety to serve, however, let us not overlook the opportunities which lie close at hand. Perhaps the greatest contribution we can make, after all, is to do our own job—and do it well. Not every nurse can go off, figuratively speaking, to Crimea; but every nurse *can* apply the same kind of creative energy to her daily work. Those who do find the routine assignment filled with satisfactions.

In our present health-defense program, it is equally creditable to be a good general staff nurse in Keokuk as a Florence Nightingale at some potential battle front. Perhaps even more so, for the general staff nurse must have the courage to serve without adulation, unspectacularly but well . . . Mary had that kind of courage, for Mary came back.

IT COMES IN *Cans!*

Whatever your branch of nursing, you'll find these facts about canned goods helpful. The author is an expert on nutrition.

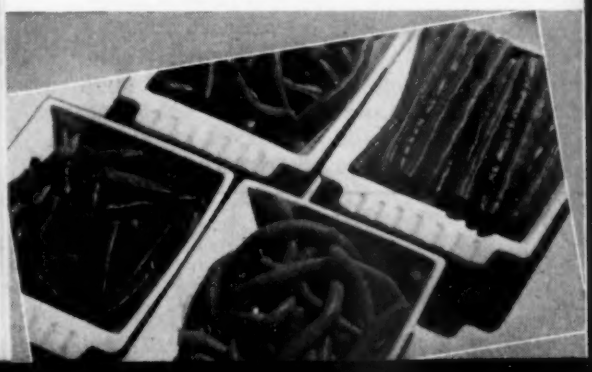
BY HELEN MORGAN

• "Seventeen thousand meals a day—and a good proportion of them come out of cans!"

Contrast this statement of an official of Bellevue Hospital in New York City, second largest city hospital in the country, with that of Grandma Smith who once boasted, "I haven't a can-opener in the house!" It's hard to believe that housewives talked like that only a decade or so ago.

Canned products are now accepted for normal family use and by hospitals and other institutions where special attention to diet is necessary. Vintage notions regarding commercially canned foods are recognized as superstitions. Canners have listened to scientific experts. They have learned how to prevent botulism, how to preserve vitamin content. Canned foods are nutritionally adequate—and they are safe.

To dispel any further chronic illusions, consider this partial list of supplies ordered by George Craig,



Bellevue's chief steward, for the next three months:

300 gallons of apple juice
1,260 cans of tomato juice
480 dozen cans of salmon
150 dozen cans of shrimp
1,200 dozen cans of evaporated milk
30 gallons of chow chow
20 dozen cans each of mince meat and plum pudding

During November, December, and January, Bellevue will buy 124,888 pounds of fresh potatoes, cabbage, carrots, onions, and turnips as compared to 11,952 cans of vegetables. Fresh oranges and bananas will total 38,460 pounds. But patients will receive apricots, cherries, grapefruit, peaches, fruit salad, pears, plums, prunes, pineapple, and fruit juices out of 4,500 cans.

Actually, Bellevue uses more canned than fresh fruits and vegetables throughout the year. Babies are served canned puréed vegetables almost entirely, the only exception being when the hospital runs out of canned stores.

Cost is an outstanding factor in influencing Bellevue and other large institutions in the choice of foods. Fresh fruits and vegetables, in season, are usually cheaper and are generally used. Waste and the expense of preparation must be added, however, to the cost of fresh foods, jolting the price considerably.

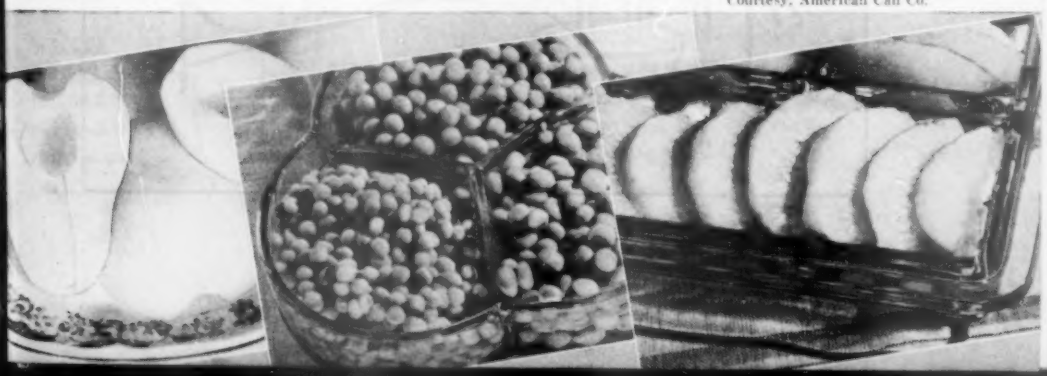
A survey of comparative costs was made a few years ago at Montefiore Hospital, also in New York City. This institution is the largest voluntary hospital for chronic diseases in the country and, during a recent six-month period, spent approximately $10,000 for canned fruits and vegetables.

According to Lenna F. Cooper, chief of Montefiore's department of nutrition and supervisor of the investigation, one bushel of fresh string beans, out of season, would cost $2.64. To this must be added about fifty cents for labor, bringing the cost to $3.14. Waste constitutes 12 per cent of the product. Four No. 10 cans, which yield the equivalent of one bushel, cost $2.56. Other studies have indicated that over a year-long period the canned product is least expensive.

Recent improvements have widened the appeal of canned foods. Nowadays, most canned vegetables are packed with only a small amount of salt for seasoning. Peas and corn sometimes have a small amount of sugar as well as salt added to the liquid in which they are canned. So far as fruits are concerned, analyses show that the total carbohydrates rarely exceed twenty per cent—and this includes the natural sugar of the fruit as well as that added in the syrup used by the canner. Thus, canned foods are blissfully like the original and are a boon to patients who are reducing or on special diets. Labels give exact information regarding vitamins, minerals, and calories in terms of carbohydrates, fats, and proteins.

Another innovation is pasteurization of citrus juices. This method, graphically termed "flash" or "high-short," is rapidly coming into use in Florida. By subjecting products to a high heat for only a few seconds, natural aroma, taste, and Vitamin C potency are preserved and storage life is prolonged. Is the heat sufficient to kill organisms that might cause spoilage? Department

Courtesy, American Can Co.



of Agriculture scientists at the Citrus Products Station in Winter Haven, Florida, after extensive experiments, decided that it is.

Despite these advances, favorite superstitions linger. We've contrived, therefore, a quick way to put the most commonplace notions in their place. Here are the questions, most frequently asked concerning canned products, and the correct answers:

Q. *Is it safe to leave food in the can?*

A. Yes.

Q. *Are preservatives added?*

A. No.

Q. *Are old, half-spoiled fruits and vegetables used in canning?*

A. No! Produce is grown especially for the canner, picked at exactly the right moment.

Q. *Are canned foods inspected?*

A. In California, where the canning industry totals a billion dollars a year, canneries are licensed by the State health department and are inspected regularly. Doubtful packs are withheld from shipment and tested. Canned meats and all soups containing meats are rigidly supervised by the Federal Meat Inspection Service. This year, the Agricultural Marketing Service, Department of Agriculture, supervised from beginning to end the canning of certain fruits, soups, and vegetables at two California canneries. Cans will soon appear on grocery shelves bearing the label, "Packed under continuous inspection by the Agricultural Marketing Service." The experiment is being watched with great interest and several State universities plan surveys to judge consumer reaction.

Q. *Does tin "poison" the food?*

A. No cases of tin or lead poisoning have ever been definitely traced to canned foods.

Q. *Is the liquid in the can worth keeping?*

A. Decidedly. It contains minerals, just as any juice from cooked food does.

Q. *Is home-canned food safe?*

A. This is a leading question. While you may have confidence in commercially canned foods, you may well be suspicious of the home-canned products. Wise nurses, visiting homes, will learn the case history of [*Continued on page* 32]

PROBIE

"Do you think we'll ever be supervisors?"

QUICK FACTS ABOUT

Blood DYSCRASIAS, II

• **Structure of the white blood cells.** —The white blood corpuscles, numbering 5,000 to 8,000 per cubic centimeter, are comprised almost entirely of leukocytes and lymphocytes. The former, making up 70 per cent of the total number of white blood cells, consist largely of polymorphonuclear leukocytes—irregular shaped cells whose many-lobed nuclei contain quantities of purple staining bodies. These "granules" are neither acid nor basic in their staining properties, hence are known as "neutrophils." Normally, about one per cent of the leukocytes are "basophils," polymorphonuclear leukocytes whose granules take a blue or basic stain, and about one to two per cent are "eosinophils," leukocytes with granules that take a red or acid stain.

The remaining 30 per cent of the white blood cells are small and large lymphocytes, small spherical bodies with a single round nucleus.

The leukocytes originate in the red bone marrow, arising from cells identical with or at least similar to those which are ultimately transformed into erythrocytes. They serve a well-defined function in protecting the organism from invasion by pathogenic bacteria. As an infectious process takes hold—whether it is a localized carbuncle or pneumonia—the bone marrow is stimulated to discharge large numbers of neutrophils into the blood stream. These cells travel to the site of the infection, agglomerate about the invading microorganisms, and destroy them by phagocytosis (engulfment). Certain investigators believe that leukocytes elaborate an antitoxin-like substance. Some neutrophils are themselves destroyed; they are liquefied in the process and discharged from the body in the form of pus. Thus, the presence of leukocytes in an exudate or a secretion is regarded as evidence of infection. "Pus cells in the urine" are leukocytes which find their way into the urine from a urethritis, cystitis, or pyelitis.

The number of leukocytes may exceed 30,000 per cubic centimeter of blood in the presence of severe infections. This increase is made up largely of neutrophils. The degree of leukocytosis is roughly proportional to the intensity of the infection. In severe infections, failure of the leukocyte count to attain the usual level, as in pneumonia for example, is regarded as an unfavorable prognostic sign since the patient is thus deprived of an important defense mechanism. Elevation of

WHITE CORPUSCLES (5,000-8,000 per cubic centimeter) —

- 70% LEUKOCYTES —
  - Approx. 98% NEUTROPHILS
  - Approx. 1% BASOPHILS (Blue staining)
  - Approx. 1% EOSINOPHILS (Red staining)
- 30% LYMPHOCYTES

the leukocyte count is interpreted as an indication of infection, and constitutes a valuable diagnostic procedure.

Some infectious diseases characteristically fail to bring about a leukocytosis and, in fact, depress the leukocyte count (leukopenia). Measles, mumps, typhoid fever, and influenza are attended by leukopenia, a characteristic finding made use of in differential diagnosis. Whooping cough leads to a lymphocytosis.

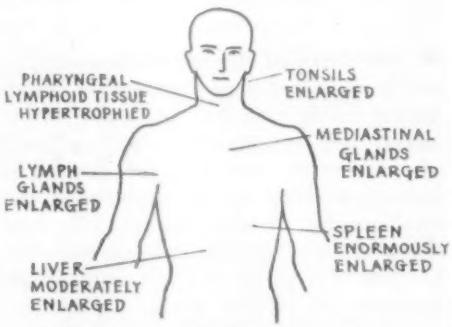
Pathologic depression of the leukocyte output is followed by a low concentration of leukocytes in the blood. This condition is known as neutropenia, agranulocytosis, or agranulocytic angina.

Parasitic infestation is usually accompanied by an increase in the percentage of eosinophils, a finding also employed in differential diagnosis.

In addition to these physiologic changes, the leukocyte count may become pathologically elevated. Acute and chronic lymphatic and myelogenous leukemia produce an enormous increase in the number of leukocytes, together with many systemic changes.

Chronic lymphatic leukemia.—A chronic disease of unknown etiology whose duration averages five to six years, chronic lymphatic leukemia may be well developed for years before the patient suspects an illness. Usually attention is called to the condition by enlarged superficial glands—those of the neck, axillae, or inguinal region. Questioning reveals that weakness, palpitation, shortness of breath, and headache have been experienced, and have increased in severity. In addition, the patient usually complains of fevers, sweats, diarrhea, and dizziness. Hemorrhages from the nose and from minor injuries are common. Generalized pruritus may be a serious feature.

Examination discloses enlargement of all lymph glands that can be palpated. The lymphoid tissue of the pharynx is hypertrophied and the tonsils, if present, are quite large. X-ray examination of the chest reveals enlargement of the mediastinal glands, producing respiratory symptoms. The spleen is enormously, the liver only moderately, enlarged. Some patients complain of a lump or fullness on the left side of the abdomen due to the splenomegaly.



CHRONIC LYMPHATIC LEUKEMIA

Examination of the blood establishes the diagnosis. The white blood count is markedly elevated, ranging from 50,000 to 800,000 cells per cubic millimeter. The white cells are small lymphocytes almost exclusively, although some leukocytes may be present. The blood, because of the large number of white cells, appears light in color and milky. A well-defined anemia is always found. This is partly due to lymphoid involvement of the bone marrow, partly to a crowding out of the erythrocytes by the lymphocytes.

A superficial gland is always removed for microscopic examination. The changes observed by the pathologist are typical and enable him to differentiate the condition from Hodgkin's disease. In the aleukemic phase, biopsy may be the only reliable means of diagnosis.

The course of lymphatic leukemia is variable. Irregularly, and without apparent cause, the white cells disappear from the blood stream and the count becomes almost normal. During this

aleukemic stage the patient is subjectively improved and usually gains in weight and strength. Then, without warning, the lymphocyte count attains its former high level.

The patient with chronic lymphatic leukemia is susceptible to many intercurrent infections. The profound weakness makes bronchopneumonia a common terminal complication.

Present methods of treatment may prolong the life of the patient but not necessarily prevent death. The most effective therapeutic measure is X-ray irradiation of the spleen, the long bones of the skeleton, and particularly of the involved lymph glands. Small but repeated doses have been found most effective. The response to the first irradiation series is usually the most satisfactory, remission usually lasting from six months to a year. When the white count again reaches 50,000 another course of X-ray treatments is prescribed. Therapy is usually discontinued when the blood count drops to 20,000 white cells per cubic millimeter. Eventually, however, the patient fails to respond. Death may occur from pneumonia, or from an acute flare-up or relapse similar to acute leukemia.

The anemia is combated with iron and arsenic compounds, although their effect is usually not great. Marked anemia can be overcome temporarily by transfusions. [*Continued on page* 42]

WOMEN IN PASTEL

BY FRANCES STANLEY, R.N.

• Public-health nurses wear blue, army nurses khaki, and air hostesses gray. We, too, have changed our uniforms to suit our special brand of nursing. At the Children's Country Home in Westfield, New Jersey, our nurses are "women in pastel"!

A few months ago, we discarded our starchy, crisp white uniforms and—steel yourselves—our caps too. Instead, we chose a short-sleeved shirtmaker style chambray in soft colors—greens, pinks, and blues. With these uniforms we wear neutral colored stockings and white shoes. Our hospital pins identify us as R.N.'s.

Our reason for abandoning the proverial white was a professional one. Our 75-bed institution cares for convalescent children, almost all orthopedic cases with a long history of previous hospitalization. White uniforms and caps remind our patients of painful experiences and rigid hospital routines. Our methods are more informal. So the modified uniform was adopted to fit our particular nursing picture.

Now Johnny Jamison, who used to scream every time a nurse approached, takes his treatments like a man. It's so much easier to get cooperation when we appear to be friends instead of disciplinarians.

We've been rather surprised by the results ourselves! We expected the children to react favorably, but we never anticipated such enthusiasm from doctors, trustees, and administrators. The hospital laundry even saves money because the new uniforms need less starch! The board of directors who looked dubious about our experiment at first, have just passed a ruling that colors are here to stay.

How do *we* like colored uniforms? We think they're wonderful. During the summer hot spell we were spared the starchy stiffness which used to make us suffer. We like short sleeves, find them sanitary as well as comfortable. Pastels, especially if there is a choice of colors, are flattering and fun to wear.

"NO SPIK ENGLISH—"

BY ROXANN

• The chap who starts a course in languages for nurses (five easy lessons, illustrated), is going to pick up a nice piece of change.

That bright idea hit me last night after district meeting when a crowd of us gathered at Tony's for coffee and talk. We found a corner where we could all babble at once, and Joe the waiter came over to take our orders.

"Tell me something, Joe," Marge inquired. "I know you come from one of the smaller European countries. As a matter of curiosity, how many languages do you speak?"

"Only four, Mees. That is, gude. Some others—what you call dialect—I try. But in thees America, it is different. You do not need besides English. . ."

"Maybe *you* don't need 'em," Marge interrupted, "but I *do*!" She shook her head sadly. "The life of an admitting nurse in a general hospital these days isn't the uneventful routine it used to be!"

"You're telling us!" "Hitler's effect on nursing!" "These refugees, poor darlings!" We looked at each other in surprise at the chorus of outbursts, and Joe scampered off to safety.

Marge, more persistent and resonant than the rest, won the floor. "It's like this," she complained. "Since we have been taking care of refugees I've almost had to develop a sign language. It's tough on me, of course, but I guess it's worse on the refugee. Last week a meek-looking little man wandered into the

"When we got him translated, we found it was all a mistake . . ."

office with an inquiring and puzzled expression. I tucked him into the waiting room for half an hour while I called medical and social workers and interpreters to find out what was wrong with him. When we finally got him translated we discovered that he had got into my office by mistake. What he really wanted was a rest room!"

Ginny, head nurse on men's surgery, interrupted our laughter. "You only *think* you have trouble!

"Just this morning I found the night nurse almost in a state of collapse when I went on duty. Old Whiskers in 2B—we couldn't pronounce his name, so we called him that—had developed fluid, and the Wangenstein suction had been ordered. The night nurse tried to explain the treatment to the patient, but he didn't understand. So she gave up and wheeled in the apparatus.

"Whiskers leaped from the bed and headed down the hall, his facial foliage flying in the breeze and the nurse in hot pursuit. Luckily, an intern on night rounds happened along and waved the finish flag over Whiskers. The nurse and the intern patted and smiled and made friendly motions and finally induced the patient to climb back into bed. But his poor old heart was skipping along about 160 and a special had to be assigned to him. All because nobody could explain what was going on."

"Given a dictionary and a couple of hunks of adhesive tape, maybe that nurse could have made out all right—as I did on the Le Soeuer case," Mary cut in. In answer to our questions she continued, "It's the case I've just been specialing. Monsieur and Madame Le Soeuer are an awfully nice French couple. Their little girl Annette developed scarlet fever and I went to the apartment to take care of the child. I've always wished I could speak French well, but I never got beyond the '*La plume est sur la table*' stage.

"On my first day, I wanted to prove my friendship and good will so I said, '*Bon jour*' when Mrs. Le Soeuer answered the door bell. She beamed like an August sun, pumped my hand, and shot a volley of French at me. Carrying my bag with one hand and gesticulating with the other, she took me to my room, still spattering me with vowels and consonants. At the first pause, I burst out desperately, '*Je ne parle pas la Français.*'

"*Mais, non?* She looked at me in utter bewilderment. But we soon worked out a system. Annette wasn't acutely ill, and she watched with a fortitude born of air raids and blackouts while I hung up a gown and fixed paper bags. Her mother trotted beside me as I selected, carried, and placed basins, tables, linen, trays, and dishes.

"Every time I touched an object I would say its name in English, then Mrs. Le Soeuer would say it in French. That was fine, as far as it went, but neither of us could remember long enough. So we cut labels from adhesive tape, and by evening everything in the

"By evening, everything in the house was plainly marked . . ."

house was plainly marked with its bilingual title. The apartment looked like a first-aid tent after a successful blitzing. When Mr. Le Soeuer came home he was so impressed with our efforts at international understanding that he rushed out and bought a French-English dictionary and a grammar. Then the fun really began! The *faux pas* we made!" Mary laughed.

"Name one," ordered Marge.

"Well, there was the night that Mrs. Le Soeuer was working in the kitchen and suddenly yelled, 'Come quickly, please. I am completely disillusioned!'"

"'Disillusioned?' I repeated like a dope, running to see what caused such a state. When I got to the kitchen it was in total darkness—the lights had gone out. Mrs. Le Soeuer meant, of course, that there was no illumination."

"Did you learn any French—really learn it?" I asked.

"I certainly did," Mary answered. "and I enjoyed doing it. I'm going to keep it up, take a course in it, to see if I can't improve my pronunciation. And, if you must know, I learned English! Annette picked up all the silly slang I used to use. It sounded so awful that I had to get down to brass tacks and speak English instead of American!"

Sue, the only public-health nurse in the crowd, was drinking her third cup of coffee and keeping very quiet. We turned on her. "Hasn't Hitler made any difference in your life?" Mary asked.

Sue put down her cup. "Not much, except for an additional case-load. We're used to helping strange people from all countries. Give me an ordinary kitchen, a baby and its mother, and we'll get together in one way or another. Strange things do happen, though." Her eyes crinkled with amusement, so we prodded her for the story.

"Well, as you know," she said, "my district is predominantly Polish. At a home delivery one day I was trying—unsuccessfully—to tell the patient to 'push.' One of the neighbors was helping, and she gave me a phrase that worked like a charm. It worked so well, in fact, that I used it on every similar occasion for months.

"Just the other day I was assisting at the *accouchement* of an expatriated Polish professor's wife. I thought I was pretty clever when I used my good old magic phrase, but the professor's wife looked so stunned that after everything was over I asked her to translate it literally for me. She did! It seemed that in my dignified professional way I had been telling the mothers in labor to 'push like hell'!"

That broke up the meeting.

DIETITIAN

● *This month, Mary I. Barber of the Kellogg Company takes office as president of the American Dietetic Association. Organized during the first World War to meet an emergency situation, this association may again enroll its members for nutritional reconstruction work . . . Miss Barber began her career as a dietitian in a Pennsylvania hospital.*

NUTRITION Briefs

● How about a baked dasheen, or a nicely boiled taro with sauce for supper? Never heard of them? They're two forms of a new vegetable which is being introduced in the United States. It's nourishing and economical, and may be a boon to those unfortunates who are allergic to ordinary starches.

For many years, taro has been a common food crop in the islands of the mid-Pacific, the Mediterranean countries, and parts of Central and South America. Its highest development has been in the Hawaiian Islands where it is available in sixty-nine different forms.

The dasheen (as it is called where it is grown in Florida), or taro, is a green leafy vegetable, with a root very similar in size, shape, and composition to the Irish and sweet potato. Unlike the potato, the taro contains 30 international units of Vitamin B per 100 grams. It also contains some calcium and 29 per cent starch.

Its greatest superiority over the potato is that two to four times as many taros can be grown on an equal amount of ground. The pulp of the vegetable may be made into a flour for bread with a high Vitamin B content. Already the Hawaiians are converting it into a food for infant formulas and a beverage powder.

Scientists have been amazed at the excellent physical development and fine teeth of the Hawaiian natives who have lived largely on taro for years. They and American farmers predict it won't be long before the taro will be grown in this country in large quantities.—*Potgieter: Taro as a Food. Jour. of Am. Dietetic Assoc. June-July 1940.*

● England's newest defense weapon is not a bomb, but a sandwich! "The Glossop," as it is slangily called by Britons, is a war-time meal, designed to keep the population healthy, though rationed.

Here's the formula: two slices of whole meal bread, margarine to cover, a layer

of dried brewers' yeast, a touch of mustard, trimmings of water-cress (or lettuce and tomato in season), and a slab of cheese (or meat, if any). Credit this combination to a Glossop doctor who, in one powerful if not appealing snack, has combined adequate protein, carbohydrate, fat, vitamins, and minerals to keep John Bull in the peak. And, displaying real fighting spirit, Britons down it with patriotic relish.

"The Glossop" is part of a campaign on the part of the Ministry of Foods to make rations safer and more protective than they were in 1914. In the last war, rationing was done in the dark. Nobody knew much about protective foods. At the end of the war, people were bowled over like ninepins with influenza and pneumonia. This time, epidemics may not develop—for the government is assigning plenty of vitamins and minerals to back up the nation's defense.

In cutting down on food, first items to go were the [*Continued on page* 40]

IN REVIEW

A QUICK GUIDE TO CURRENT BOOKS OF INTEREST TO NURSES

COMMON CONTAGIOUS DISEASES.

Philip M. Stimson, M.D. $4.00. *Lea & Febiger. (Third edition.)*

● Here is a concise, factual summary of contagious diseases. Nurses will like it for reference work. On the whole, however, the emphasis in this manual is diagnostic and medical. Apparently designed primarily for medical students, pediatricians, and health officers, the book often glosses over the nursing problems in a variety of special diseases.

Nine new color photographs showing rashes in scarlet fever, measles, chicken pox, and smallpox, should be especially useful in teaching programs. The book also contains a careful account of hospital communicable-disease techniques and a section on various methods of disinfection and sterilization.

DERMATOLOGY AND SYPHILOLOGY FOR NURSES.

John H. Stokes, M.D. $2.75. *W. B. Saunders Co. (Third edition.)*

● Fever therapy and the use of sulfanilamide in venereal disease are two new items in the revised edition of Dr. Stokes' book. In response to requests from many nurses, he has also added a practical section on the care of bedsores. For the public-health nurse there is an up-to-date chapter on contact tracing and the handling of V.D. cases. This is the contribution of Louise Ingraham of the social-service department of the University of Pennsylvania hospital.

The author's case is so well presented that the reader is inclined to overlook occasional departures from the scientific objectivity which, for the most part, prevails. Such sentimental lapses as the doctor's comment on Woman, however, may provoke at least an occasional chuckle: "Only she has the patience to put on the little booties, wash the little didies, press

the little frills on the little dresses, and cherish the little thank-yous." Chivalry, dear reader, is *not* yet dead!

MEDICAL DISEASES FOR NURSES.

Arthur A. Stevens, M.D., *and Florence A. Ambler,* R.N. $2.75. *W. B. Saunders Co. (Fourth edition.)*

● The excellently compiled medical facts in this volume are wisely coordinated with a good deal of nursing material. The combination makes a dependable reference and textbook. Miss Ambler's sections on nursing care are up-to-date and explicit. She doesn't skip such important details as positions in bed, special danger signs in individual diseases, and suggestions on the relationship of nurse to visitor.

It is probably splitting hairs to point out that, in the opinion of this reviewer, the text may be a little *too* thorough for practical purposes. The author attempts not only a complete review of diseases of all the body systems but includes also such rarities as leprosy, plague, and relapsing fever. There hasn't been an epidemic of the latter in America since 1869. Overabundance, however, is a minor fault in this case. The book is carefully organized and well-indexed.

It comes in cans!

[*Continued from page* 22]

every jar of home-canned food that's served. The danger of botulism is always present. (See "Quick Facts About Food Poisoning," R.N., July 1940.)

The Bureau of Home Economics of the Department of Agriculture examined 3,434 jars of home-canned meats, fish, corn, limas, and peas, and found that 48 per cent showed by appearance, odor, or flavor signs of spoilage. A bacteriological analysis would probably have yielded an even higher percentage.

Very often spoilage is considered harmless and food is eaten anyway. It should be remembered that the *B. botulinus* is a spoilage organism and any non-acid canned food which appears spoiled probably is. The growth of *B. botulinus* spores is inhibited only in products having a PH. below 4.5, which includes nearly all

Helps KEEP the SICK ROOM personally "AIR-CONDITIONED"

Personal "air-conditioning" of patients with MUM, the snow-white cream deodorant, helps to minimize sick room air staleness. MUM quickly neutralizes stale perspiration odors. A fresher atmosphere results in thankful patients . . . And why not give yourself a daily "air-conditioning" with MUM?

MUM Takes the Odor out of Stale Perspiration —Does Not Interfere with Normal Sweat Gland Activity.

It's a fact — MUM on sanitary pads keeps your secret.

A Boxful of Freshness — A dab of soothing MUM, applied to underarms and other skin areas, maintains personal freshness by banishing stale perspiration odors. Quick, non-irritant; does not stain clothing or bed linens.

Personal "air-conditioning" as herein used applies to the removal of stale perspiration body odors which occasionally permeate an office or room.

BRISTOL-MYERS COMPANY

19-D WEST 50th STREET NEW YORK, N. Y.

fruits. Fruits, therefore, may usually be canned in boiling water. Non-acid foods (including meats and vegetables and particularly string beans, corn, olives, spinach, beets, and asparagus), are safe only when processed under steam pressure *correctly used*. Bulletins recommending canning processes, issued by State departments, clubs, newspapers, and other sources are often erroneous. Best advice to follow is that contained in the Farmer's Bulletin, No. 1471, of the Department of Agriculture.

Perhaps you've wondered why we didn't consider the question, "Does canning reduce the nutrition values of food?" The answer is "no," but the query deserves fuller scrutiny.

Canned food is not, as many suppose, mysteriously processed. Foods are picked and prepared much as any housewife would fix them, occasionally pre-cooked and then subjected to a heat treatment in a sealed container. Their nutritional value is, therefore, comparable to that of any other cooked food. Canned foods, however, differ from cooked foods in that they are canned right after picking. Thus, vitamins have no chance to vanish during transportation and marketing. Furthermore, the cooking process is scientific and controlled. It is aimed at preserving not only palatability and good appearance but also as much as possible of the vitamins and minerals contained in the food.

A study* of the reactions of vitamins to the canning process yielded the following valuable information:

Vitamins A, B_1, B_2, and D are resistant to heat and are, therefore, unaffected by the high temperatures used in canning. Vitamin A is subject to oxidation; canning, consequently, is less destructive than ordinary cooking in an open pot. Heating foods containing Vitamin A in the can, as directed, will prevent further oxidation. Both Vitamin B_1 and B_2 are soluble in water

*M. A. B. Fixsen, Nutritional Abstract and Review.

Mrs. L.: Things are looking up, doctor. I feel pretty good—until my nurse cuts across the view!

Doctor: I—ah, see what you mean. But she's a very good nurse, despite that uniform.

Mrs. L.: But can't she be a good nurse and STILL wear a uniform that fits? Just look at that hem line—it's *two inches* too high!

Doctor: Yes, it certainly looks like "little sister's." But—

Mrs. L.: And it's shrunk so she can hardly raise her arms to her shoulders. I thought she'd drop that tray all over me.

Doctor: Yes—ah, I suppose the constant washings do rather shrink cotton fabrics. Too bad there isn't some process that will hold their fit.

Mrs. L.: Don't tell me you've *never heard* of *"Sanforized-Shrunk"* which controls shrinkage to a measly 1%?

Doctor: Well, I have, as a matter of fact. My shirts have a label that uses those very words.

Mrs. L.: Why, it's the *one process in the world that keeps cotton fabrics from shrinking out of fit.* I always insist on "Sanforized-Shrunk" for my maids' uniforms.

Doctor: WELL—I'll just pass that on where it'll do the most good! It's too bad, you know, to BE a smart nurse—and not LOOK the part!

For permanent fit, look for the words

SANFORIZED-SHRUNK

and are partly lost during any washing or cooking. Saving the water in which food is cooked will help retain the vitamin. Vitamin C is affected by heat, washing, and storage. The content diminishes after picking (which gives canned food an advantage over fresh food that is transported to market), and during storage, whether canned or fresh. Food recently canned has the highest percentage of this vitamin. Added Vitamin C may be provided in the diet through raw fruits and vegetables.

Because they are infinitely more convenient to use than fresh fruit, canned fruit juices today are used by millions of people who depend on these products for their supply of Vitamin C. Their confidence is not misplaced, the Council on Foods of the American Medical Association decided after an analysis of the fruit juices. Adults require from 600 to 1000 international units of that vitamin daily. More than enough can be obtained by drinking daily one large glassful of any juice. A twelve-ounce cup of canned lemon juice, the council determined, yields 2,500 units; canned orange juice, 2,250; canned grapefruit juice, 1,875; canned pineapple juice yields 750. An eight-ounce cup of tomato juice gives not only 900 units of Vitamin C, but also 1000 units of Vitamin A, which amounts to half the daily adult need. Since there are only about fifty calories in this quantity, it's readily seen why tomato juice is a valuable asset for those who wish to lose weight. Ease of preparation, plus high vitamin content, make these products almost indispensable for patients on liquid diets.

Canned salmon is another important item in reducing and low-cost diets. It is an inexpensive source of protein, contains all the essential amino acids, and is rich in minerals. It is usually packed plain, which means it is less fattening than tuna (commonly packed in cottonseed oil), or sardines (which

contain tomato sauce or olive oil).

According to the Bureau of Home Economics, canned salmon contains both Vitamin A and Vitamin D. A study of four types of salmon revealed that red salmon is probably the best buy for it has more Vitamin D than any other type and the second largest amount of Vitamin A. Chinook, the most expensive and containing the most Vitamin A, ranks with Chum (the least noteworthy and the cheapest) in its Vitamin D content.

So you can readily see that canned foods are both economical and nutritious. Next time someone looks at you askance and cries, "So you cook out of cans!" don't be apologetic. Come to think of it, a hefty can-opener wouldn't be a bad Christmas present!

[*Next month, Miss Morgan suggests ways of using canned foods.*—THE EDITORS]

Defense at home

[*Continued from page* 15]

Here are some possibilities worth considering:

ORGANIZATION MEMBERSHIP: Since defense plans are being carried out through official channels, you can be most useful if you are a member of the A.N.A. Your local unit will need help in getting survey returns, in making future defense plans.

GOVERNMENT SERVICE: Are you qualified for the Army or Navy Nurse Corps, for the U.S. Public Health Service, the Veterans' Administration, or Indian Bureau? (See chart.) With expansion in all these departments, new executive positions will open up. At present, the U.S. Civil Service Commission is accepting applications for examinations for the post of Junior Graduate Nurse in the three latter departments.

RESERVE CORPS: Whatever your status, you are eligible for one of the Red Cross reserves. "The A.R.C. is encouraging enrollment of all nurses at this time," said Mary Beard, national director. Member-

ship in the first reserve doesn't mean you *must* serve when called. It simply indicates your immediate availability and fitness. A first reserve nurse must be 21-40 years of age, single, graduate of an accredited school of nursing, member of the A.N.A., and an American citizen. The Red Cross wants at least 10,000 new first reserves. Second reserve nurses are those who are over 40, or married, and so are ineligible for active military duty. Third reserve nurses are those who are not actively nursing now. Army reserve nurses must fulfill the requirements of the Red Cross reserve. Navy reserve nurses may apply directly to the navy, must be 22-45 years of age, single, high-school graduates, who trained in an accredited nursing school. They must pass a navy physical examination.

BASE HOSPITAL UNITS: Large hospitals all over the country are organizing medical and nursing groups to serve as units in war time. These units will be smaller, more mobile, than those in the last war. A base hospital unit usually includes about forty physicians and 120 nurses. R.N.'s must be members of the Red Cross first reserve, since the units are organized under army standards. Your county medical society will be able to tell you how to volunteer.

AIR TRAINING: With expansion of aviation, nurses must know how to carry on procedures during air transport. Only nurse group to offer this type of training is the Aerial Nurse Corps of America. With headquarters in Burbank, California, it has branches in many cities throughout the country. As official nursing division of the American Aeronautic Association, it provides courses in transporting and caring for patients in modern type planes. ANCOA cooperates with the Red Cross, and the A.N.A.

HOME HYGIENE COURSES: Can you teach home hygiene and care of the sick? There will be greater demand for these courses, given by the Red Cross, and your local chapter will be looking for R.N.'s who know people and are up on techniques. Frederika Farley reports for the New York City chapter of the A.R.C. that the demand for courses, and for teachers, is

rapidly mounting. Graduates of Red Cross courses are not prepared to work for hire, but would be used in times of national defense to fill in at rush hours in the nursing day—at morning bath time, and meal times. Ask at your local Red Cross office, if you want to teach.

COURSES AND INSTITUTES: Throughout the Winter, district and State meetings on defense will be held. You can help by participating. Ask the secretary of your district association.

SPECIALTIES: If you have any special training or abilities, this is a good time to brush up. Nurses with special knowledge of surgery or orthopedics, teaching or administration, will be much in demand.

Remember one thing—whatever you're doing, whether it's general staff duty, private duty, or public health, Uncle Sam thinks you are valuable where you are. These days, there's a community front—and you are one of its responsible personnel.

Nutrition briefs

[*Continued from page* 29]

non-protective dishes, no matter how tasty. Next omitted from the nation's diet were the low-vitamin foods which are usually expensive to produce, and hard to import.

Coffee, tea, chocolate, and sugar have been strictly rationed—they're labeled non-protective. Livestock has been classed as a wasteful mechanism for converting large quantities of plant materials into smaller amounts of flesh, milk, and eggs. So meat has been eliminated to a large extent. Menus for the home folks, as well as for the army, have become increasingly vegetarian.

Milk has been termed an absolute necessity only for babies and school children. For, under emergency food rationing, Britain's medicos consider cow's milk an incomplete and expensive food with little vitamin and iron value. Even babies may have to cut down on their milk consumption later. If the need should arise, doctors say it will be possible to devise a satisfactory milkless vegetarian diet for newly weaned infants! (In this war, Den-

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mark's butter, milk, and cheese is feeding Britain's enemy.)

Throughout England, unrefined cereals and bread flours—providing Vitamin B in its best and cheapest form—have been substituted for expensive milled products. Margarine, which now appears everywhere on dinner-tables, has been fortified with Vitamin A and D.

This shift of an entire nation from its favorite indigestible foods to a "good-for-you" regime, would hardly have transpired had there been no Battle of Britain. But, for his country's convictions, John Bull will relinquish even his sacred beef, his Port, and his generous slice of Yorkshire in favor of a balanced diet.

After more than a year of war, there is no real food shortage in Britain. But England looks forward to a longer war. The fighting forces are hungry and needing nutritious fare. As for the civilian population, it is four million greater than it was in 1914, and likely to get hungry too . . .

From such factors stems the historic rise of "The Glossop Sandwich." Perhaps we in America, as a health-defense measure, would profit under a similar dietary regime, exemplified here by some such masterpiece of culinary skill as the Kalamazoo Kake or the Princeton Pattie.—*Plimmer, R. H. A.*, D.SC. *Newer Knowledge of Nutrition in Relation to War-Time Food. Public Health, London. Summer, 1940.*

Blood dyscrasias

[*Continued from page* 25]

Chronic myelogenous leukemia.—The features of this condition are similar to those of chronic lymphatic leukemia. The disease occurs in middle age, and its etiology is entirely unknown. It is believed by some investigators to be related to the neoplastic diseases. Its duration is usually from two to eight years, although some

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patients have lived more than ten years after the initial diagnosis.

The symptomatology consists of progressive weakness, lethargy, dyspnea, fever, sweats, loss of weight, cough, and pallor. Loss of appetite, vomiting, and constipation are not uncommon. A hemorrhagic tendency is frequently observed, and is manifested by epistaxis, hemoptysis, and bleeding from the bowel. Generalized itching of the skin is experienced by many patients, and because of the difficulty with which it is controlled, may become exceedingly uncomfortable.

The spleen of chronic myelogenous leukemia is enormously enlarged, and often calls the patient's attention to his illness; the organ may weigh in excess of 10 pounds and may extend into the pelvis and to the right of the umbilicus. The liver is also enlarged, but to a lesser extent. The increased size of these two organs usually causes protrusion of the abdomen and leads to troublesome digestive disturbances. Enlargement of the lymph glands is only rarely encountered in chronic myelogenous leukemia.

Hematologic study, of course, makes the diagnosis clear. The white blood count is usually above 100,000 cells per cubic millimeter, and may be more than 1,000,000. The cells are largely leukocytes or immature leukocytes; the lymphocytes are reduced in proportion. Secondary anemia is always encountered, and is most severe when the white count is highest.

Periods of spontaneous remission alternate with periods of exacerbation. An aleukemic phase may persist for months with marked subjective improvement.

Patients with chronic myelogenous leukemia are especially susceptible to infections such as abscesses, carbuncles, furuncles, erysipelas, tonsillitis, and pneumonia. Many develop a tuberculous infection which runs a rapid course.

Treatment consists of X-ray therapy, given according to the general plan outlined for chronic lymphatic leukemia. The spleen, liver, and long bones receive the irradiation. Transfusions and iron therapy are employed to overcome the associated secondary anemia. Splenectomy is advised by some surgeons, but is not accepted as being uniformly effective.

Acute leukemia.—A disease of child-

hood, acute leukemia is rapidly fatal, terminating in from a few days to several weeks. Its etiology is unknown.

Two varieties are distinguishable on the basis of blood findings: the lymphatic and the myelogenous. However, since the clinical pictures of both are virtually identical, they will be discussed together.

The onset of acute leukemia is abrupt. A chill and fever usher in the illness which is characterized by a severe sore throat, cervical lymphadenitis, malaise, and prostration. The oral infection rapidly becomes more severe, assuming the character of a gangrenous stomatitis. Pain in the mouth and throat may be great, and the sloughing tissues produce a most disagreeable stench. The liver, spleen, and lymph glands are not enlarged to the extent seen in the chronic forms of leukemia. Complete anorexia and the mouth infection make eating a hardship. Moderate subcutaneous hemorrhages develop at various locations; bleeding into the retina is not uncommon.

The state of the patient becomes more serious in spite of vigorous therapy. Septicemia or pneumonia usually terminate the condition and, because of their frequency, can hardly be termed complications.

Acute leukemia is easily mistaken for septic sore throat or Vincent's angina, although careful examination of the blood readily discloses its true nature. The white blood cells number 20,000 to 500,000 per cubic millimeter. They are immature varieties, the myeloblast being the predominant cell in the leukemic form and the lymphoblast the chief cell in the lymphatic form. This merely means that the process is so acute that the white blood cells are poured into the circulation before they can develop to maturity. A rapidly progressive secondary anemia is also detected by the blood examination. At times, an aleukemic phase of acute leukemia is encountered, especially in the early stages. However, the blood picture promptly changes and the number of white blood cells quickly reaches the characteristic high level.

The clinical features which typify acute leukemia may suddenly develop in a patient with chronic leukemia. This phenomenon is seen in the advanced

stages of the chronic variety, and usually ends fatally.

While acute leukemia terminates in death in most instances, some patients may develop the chronic form. On an arbitrary basis, if the patient lives for more than six months, he is regarded as having entered the chronic phase.

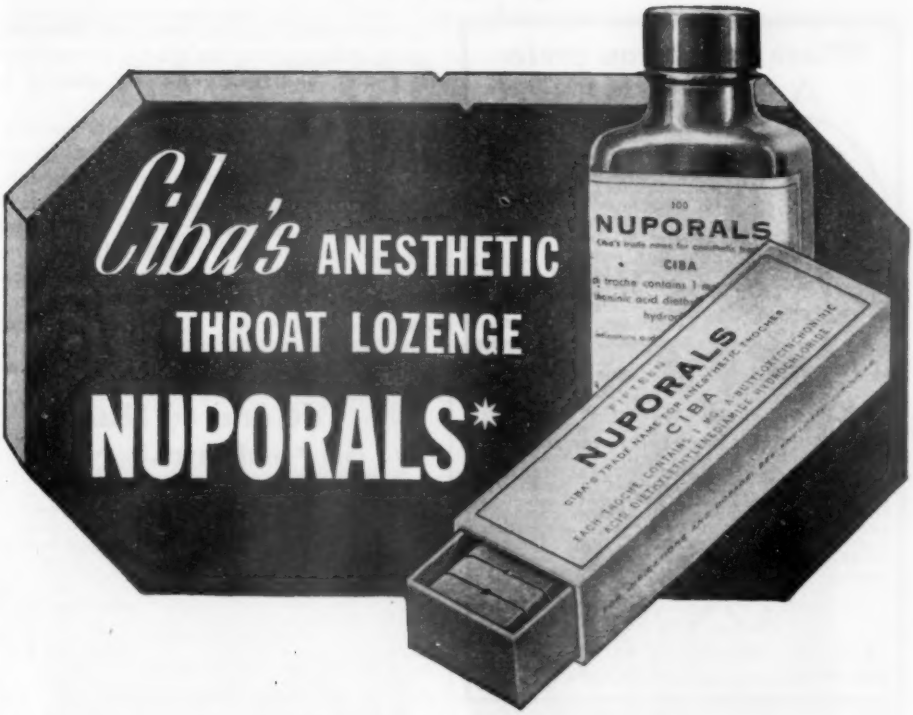
As no specific cure has been found, treatment consists largely of nursing care. The extreme discomfort of the patient is relieved by frequent cleansing of the mouth and pharynx with antiseptic and deodorizing washes. Pain is controlled by means of analgesic agents; sedatives are given freely. Transfusions are only of temporary benefit. X-ray therapy is definitely contraindicated since it is of no value and may actually be harmful.

Agranulocytosis.—Neutropenia (agranulocytic angina or agranulocytosis) was first described relatively recently, in 1922. As its name implies, it is characterized by a decrease in the number of polymorphonuclear leukocytes in the circulating blood.

Clinically, agranulocytosis develops suddenly, quickly leading to prostration and to elevation of the temperature. Ulcerative lesions are seen on the lips, tongue, cheeks, pharynx and vulva. Typically, few other objective signs are detectable. The white blood count is exceedingly low, usually 500 or less. Direct examination of a blood smear reveals that the white cells are virtually all lymphocytes, and that few if any leukocytes are discernible. Anemia is not marked.

It is believed that the ulcerations of the mucous membranes are due to the absence of the protective influence of the circulating leukocytes. The micro-organisms which are always found in these locations readily invade the tissues and develop unopposed, since no resistance can be offered them.

During the past few years convincing evidence has been presented which indicates that certain drugs are capable of producing agranulocytosis. Notable among these is aminopyrine, but dinitrophenol, cinchophen, and quinine have also been held etiologically responsible. The large amounts of these drugs consumed and the relatively infrequent incidence of agranulocytosis indicate that sensitivity to these



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agents is anything but common. However, since aminopyrine can readily be replaced by other analgesics, its use should be abandoned.

Until recently the mortality rate of agranulocytosis was in excess of 75 per cent. However, by means of transfusions, and through the use of intramuscularly administered pentnucleotide, the mortality rate has dropped to below 15 per cent.

[*For a bibliography of the procedures discussed in this and the preceding article on blood dyscrasias, send a stamped, addressed envelope.*—THE EDITORS]

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THE TRACE ELEMENTS IN BIOLOGICAL MATERIALS

● Students of nutrition recognize a total of some thirteen inorganic elements either as essential to humans or, in our present state of knowledge, as probably desirable for complete nutrition. For certain of these elements—definitely proven to be essential—reasonable estimates of the daily human requirements have been made. In addition, the distribution in common foods of minerals, especially those essential minerals most apt to be deficient in the diet, is well understood. Certainly, enough information appears to be at hand to insure an optimal supply for the individual of these essential or desirable elements through modern diet planning.

However, for many years it has been known that traces of elements, other than those known to be essential, may be present in animal and plant tissues (1, 2). Improvements in analytical techniques have been made and greater precautions observed in the handling of the materials used for analysis in studies reported within recent years. The results of these newer investigations have only served to confirm the fact observed in the older studies, namely, that "trace elements" may be present in biological materials, including mammalian tissues, along with the other elements recognized or accepted as essential in nutrition.

A fairly complete list of the trace elements includes silicon, aluminum, fluorine, nickel, arsenic, bromine, rubidium, barium, and selenium. The persistent occurrence of these elements in foods and in animal tissues logically raises two questions: First, are these elements essential in human nutrition, and second, assuming them to be essential, how might an adequate supply be obtained?

For the first of these two questions, there is as yet no conclusive answer (1, 2). Study of the possible part the trace elements may play in normal body functions comprises one of the frontiers of nutritional research. The fact that the trace elements are more or less consistently present in animal tissues is not necessarily conclusive proof of their essential character in nutrition; further research alone must decide that point.

The second of the above questions can be answered somewhat indirectly. It is not illogical to believe that we already recognize as essential those elements whose serious deficiency in the diet may produce the most serious irregularities in the human organism. Further, as stated above, the distribution of the known essential minerals in foods is well understood and by modern diet planning an adequate supply of these nutrients should be readily attained. It is not meant to imply that all of the trace elements are without significance in human nutrition, or that one essential nutrient is more important than another. Instead, it is intended to suggest that the distribution of all elements in foods is probably such that a protective diet—calculated to supply optimal amounts of all known essential minerals—should also supply the proper amounts of any unknown essential elements, as well.

Thus, the need for following the modern pattern of diet formulation is further indicated. The most practical means of insuring the needed quantities of all essential nutrients—recognized or as yet undiscovered—is to plan the ration according to the concepts and teachings of the modern science of nutrition. In pursuing the modern diet pattern (2), commercially canned foods should prove both valuable and convenient.

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REFERENCES

1. 1939. Mineral Metabolism, Alfred T. Shohl, Reinhold, New York.
2. 1939. Food and Life, Yearbook of Agriculture, U. S. Dept. Agri., U. S. Government Printing Office, Washington, D. C.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-fourth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

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GENERAL DUTY: California. Young nurse, for small hospital. Salary, $95; board and laundry; room out. (Placement bureau charges $2 registration fee.) Box C255.

GENERAL DUTY: Massachusetts. Boston vicinity. Fairly large hospital. (Placement bureau charges $2 registration fee.) Box MB10-3.

GENERAL DUTY: Midwest. Obstetrical and tuberculosis services of large municipal hospital; for latter service, nurses who have had tuberculosis experience required. Salary, $90; complete maintenance. (Placement bureau charges $2 registration fee.) Box MB10-5.

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PHYSIOTHERAPIST: Florida. Graduate, eligible membership American Physiotherapy Association. Experience with spastic paralysis cases desirable. Salary, $100; maintenance. (Placement bureau charges $2 registration fee.) Box C269.

RECORD LIBRARIAN: Ohio. Experienced young record librarian having membership in American Association of Medical Record Librarians required. Must be unmarried. Catholic; over 25 years of age. Should also be capable medical stenographer. Salary, $100. (Placement bureau charges $2 registration fee.) Box MB10-13.

SUPERINTENDENT: West. R.N. to take charge of hospital to be opened within next six months. Previous organizing experience desirable. Excellent connections. (Placement bureau charges $2 registration fee.) Box MB10-14.

SUPERINTENDENT: Wisconsin. For lovely and well-equipped hospital of medium size; pleasant accommodations and living conditions. Salary open. (Placement bureau charges $2 registration fee.) Box C274.

SUPERINTENDENT OF NURSES: Children's hospital. Training and experience in children's hospital required. (Placement bureau charges $2 registration fee.) Box MB10-15.

SUPERINTENDENT OF NURSES: Southeast. For 115-bed hospital in southeastern university town; need responsible person with training and ability to assist in organizing all departments. Salary open. (Placement bureau charges $2 registration fee.) Box C276.

SUPERVISOR, CLINICAL INSTRUCTION: Midwest. Two assistants will help carry out the program of instruction planned by the supervisor; 400-bed municipal hospital. (Placement bureau charges $2 registration fee.) Box B10-16.

SUPERVISOR, MEDICAL: Northwest. Good organizer needed. Must be qualified to handle combination student and graduate staff. Fairly large hospital. (Placement bureau charges $2 registration fee.) Box MB10-17.

SUPERVISOR, NIGHT: California. Mature person, who has been superintendent of hospital or in similar executive work before, desired. Must be qualified to take complete responsibility for fairly large institution at night. (Placement bureau charges $2 registration fee.) Box MB10-18.

SUPERVISOR, OBSTETRICAL: California. Busy department, averaging 45 deliveries monthly. Beautiful hospital located in residential section. Salary, $100; maintenance. (Placement bureau charges $2 registration fee.) Box MB10-20.

SUPERVISOR, OBSTETRICAL: Hawaiian Islands. New, well-equipped department. (Placement bureau charges $2 registration fee.) Box MB10-19.

SUPERVISOR, OUT-PATIENT: New England. Nurse with public-health background and record of good organizing ability required. Community hospital located in historic New England city. (Placement bureau charges $2 registration fee.) Box MB10-22.

SUPERVISOR, OUT-PATIENT: Pennsylvania. To take charge of out-patient and accident departments in fairly large hospital. Vicinity of Philadelphia. (Placement bureau charges $2 registration fee.) Box MB10-21.

**Not listed by placement bureau.*

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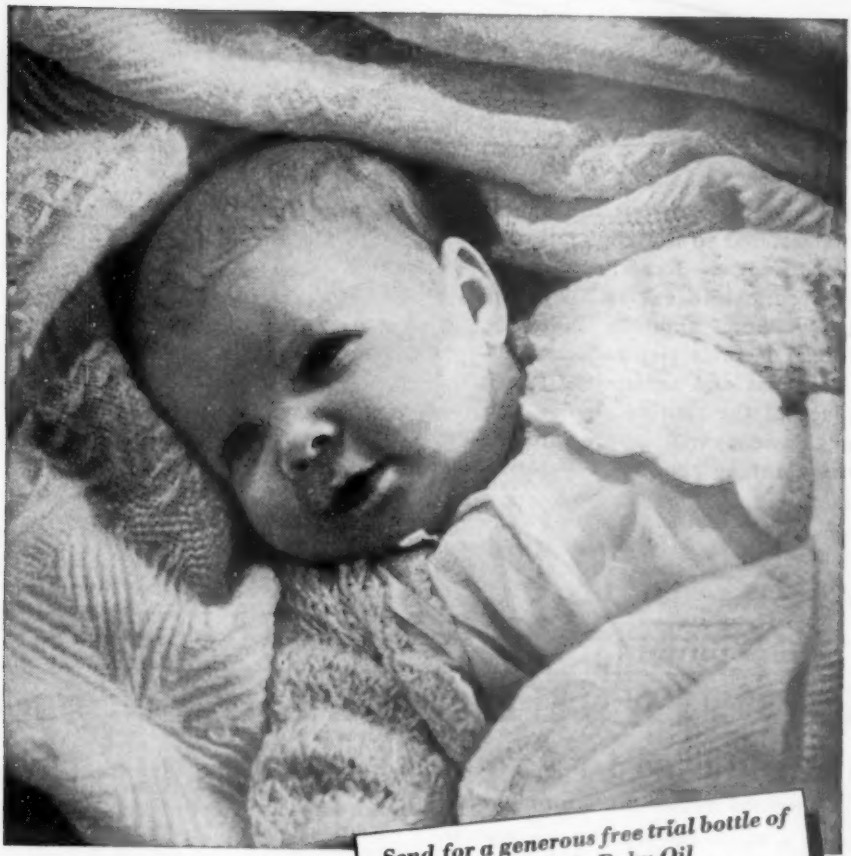

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